VIRGINIA MEDICAID REQUEST FOR SERVICE AUTHORIZATION

for Entresto™ (sacubitril/valsartan)

COMMONWEALTH of VIRGINIA
Department of Medical Assistance Services

Requests for service authorization (SA) must include patient name, Medicaid ID#, and drug name. Appropriate clinical information to support the request on the basis of medical necessity must be submitted. Please include all requested information; incomplete forms will delay the SA process. **SUBMISSION OF DOCUMENTATION DOES NOT GUARANTEE COVERAGE BY THE DEPARTMENT OF MEDICAL ASSISTANCE SERVICES AND FINAL COVERAGE DECISIONS MAY BE AFFECTED BY SPECIFIC MEDICAID LIMITATIONS.**

The completed form may be **FAXED TO 800-932-6651.** Requests may be phoned to 800-932-6648.

Requests may be mailed to: Magellan Medicaid Administration / 11013 W. Broad Street, Suite 500/ Glen Allen, VA 23060 / ATTN: MAP

Today's Date: ___ ___/___ ___/___ ___ ___ ___ Requested Start Date: ___ ___/___ ___/___ ___ ___ ___

PATIENT INFORMATION

Name: (Last, First) _____ **Medicaid ID#:** ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___

Date of Birth: ___ ___/___ ___/___ ___ ___ ___ **Gender:** □ **Male** □ **Female**

DRUG INFORMATION

Drug Name/ Form: _____ **Strength:** _____

Dosing Frequency: _____ **Length of Therapy:** _____

Quantity per day: _____

DIAGNOSIS AND MEDICAL INFORMATION – Please Answer All Questions To Facilitate Processing

Sacubitril/valsartan (Entresto™), a combination of a neprilysin inhibitor and an angiotensin II receptor blocker (ARB)
To receive a 1year month SA for this drug, please complete the questions below

Does the patient meet the following criteria?

- Diagnosis of chronic heart failure (NYHA Class II-IV) ☐ Yes ☐ No
- Has a Left ventricular ejection fraction ≤ 40% ☐ Yes ☐ No
- **Does Not** have a history of angioedema related to previous ACE inhibitor or ARB therapy ☐ Yes ☐ No
- **Has Not Used** an ACE inhibitor within 36 hours of starting sacubitril/valsartan or during therapy ☐ Yes ☐ No
- **Is Not** a diabetes who is taking aliskiren ☐ Yes ☐ No
- **Is 18 years** of age or older ☐ Yes ☐ No
- **Is Not** pregnant ☐ Yes ☐ No

Other information:

PRESCRIBER INFORMATION

Name/Specialty (print):_____ NPI Number: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___

Phone Number: (___ ___ ___) ___ ___ ___-___ ___ ___ ___ Fax Number: (___ ___ ___) ___ ___ ___-___ ___ ___ ___

Signature of Prescribing Provider: _____

PLEASE INCLUDE ALL REQUESTED INFORMATION
INCOMPLETE FORMS WILL DELAY THE SERVICE AUTHORIZATION PROCESS

FAX TO 800-932-6651
SERVICE AUTHORIZATION CRITERIA IS SUBJECT TO CHANGE AND THUS DRUG COVERAGE
http://www.virginiamedicaidpharmacyservices.com